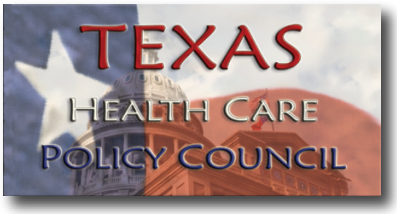

Texas Health Care Policy Council

-Policy Report-
Optimizing Pharmaceutical Purchasing in Texas

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Executive Summary

Since July 2006, the Health Care Policy Council (the Council) has considered options to reduce or control future costs of state prescription drug purchases. These considerations are consistent with the Texas Health and Safety Code, Section 113.001, which directs the Council to ensure the most effective collaboration among state agencies in the purchase of health care products or services.

This report is intended to serve as a resource guide to policy-makers. It provides information, considerations, conclusions, and recommendations regarding several pharmaceutical purchasing options. Recurring issues explored previously by committees, councils, and legislators, are addressed with updated information. Several additional optimization options are also examined.

Findings in this report include the following:

Survey of Current Pharmaceutical Purchasing Strategies

Consideration of the unique purchasing needs and obligations of various state agencies and systems need not be forfeited when considering how to optimize pharmaceutical purchasing. Opportunities exist for agencies and systems to learn from each others' purchasing strategies and practices. Continued dialogue between state agencies and systems should be encouraged and facilitated.

Drug Price Comparison

While several prices for the same drugs were found across agencies and systems, it is difficult to apply the same cost considerations across all agencies and systems. Each agency or system has unique considerations for its populations, programs, and where applicable, contracts.

Mail Order and Retail Sales

Because of the diversity of populations, needs, and preferences across the state, retaining both mail order and retail sale options would preserve plan members' ability to make choices about how they wish to pursue the purchase of their pharmaceuticals.

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Multi-State Drug Purchasing Pools

Because of its large size and purchasing volume, it is unlikely that Texas would benefit from joining with other states to reduce Medicaid Vendor Drug Program (VDP) expenditures. Furthermore, if Texas were to join its Medicaid VDP purchasing with other states, it would be compelled to make statutory changes that would ultimately compromise the program's high standards for its purchasing review and decision-making. In the event these changes were agreed to and made, it is unlikely Texas would achieve any improvement to the Medicaid VDP or realize any cost savings. As for pooling pharmaceutical purchasing for Texas public employees with other states' public employees or programs, several compromises and considerations must be carefully weighed and negotiated amongst several states to be considered beneficial to all participants. The Rx Issuing States (RxIS) experience demonstrates that this approach was ultimately unsuccessful. Again, Texas' large size (i.e. high purchasing volume) makes it difficult to justify the effort required to join with other states to achieve what most would consider a labor-intensive compromise that has a high likelihood of failure.

340B Drug Pricing

Agencies and programs that qualify for 340B pricing advantages should be encouraged to pursue participation in the program. Additionally, for those agencies that actually purchase pharmaceuticals, qualifying agencies should be encouraged to partner with non-qualifying agencies to expand overall 340B pricing advantages to the state when it is clear the advantages for doing so (e.g. increased savings to the state) would outweigh disadvantages (e.g. reduced pharmaceutical choices or forfeiture of existing pharmaceutical contracting advantages).

State Pharmaceutical Assistance Programs

For Community Mental Health Centers, it is highly likely that if a State Pharmaceutical Assistance Program (SPAP) strategy were utilized, Patient Assistant Programs (PAP) discounts offered by manufacturers would be jeopardized. It is unclear to what extent manufacturers would lower their discounts, but it is possible that community health centers would not be able to recapture the same level of savings if they also utilized SPAP strategies. For the County Indigent Care Program, because of the variability in the program, and too many counties that do not report activity, there appears little advantage to imposing this pricing strategy on this program. For the Primary Health Care Program, because of the variability in the programs, and the small percentage of expenditures dedicated to pharmaceuticals, there appears little advantage to imposing this pricing strategy for this program.

Reverse Auctions

Reverse auctions work best for the procurement of standardized commodities produced by several vendors. This purchasing model, applicable only to those agencies that actually purchase pharmaceuticals, has limited applicability to sole-source (i.e. "brand name") pharmaceuticals because the goal of promoting vendor competition to drive down prices is not achievable. The model may, however, prove advantageous for the procurement of generic pharmaceuticals because more than one manufacturer is developing and selling these products. To be advantageous, several vendors should be able to compete for the business; depending on the generic product desired several vendors may, or may not, be available to participate. The procurement of pharmaceutical supplies may best utilize the reverse auctioning model. These items are less prone to variance, which means that several vendors may supply the desired product.

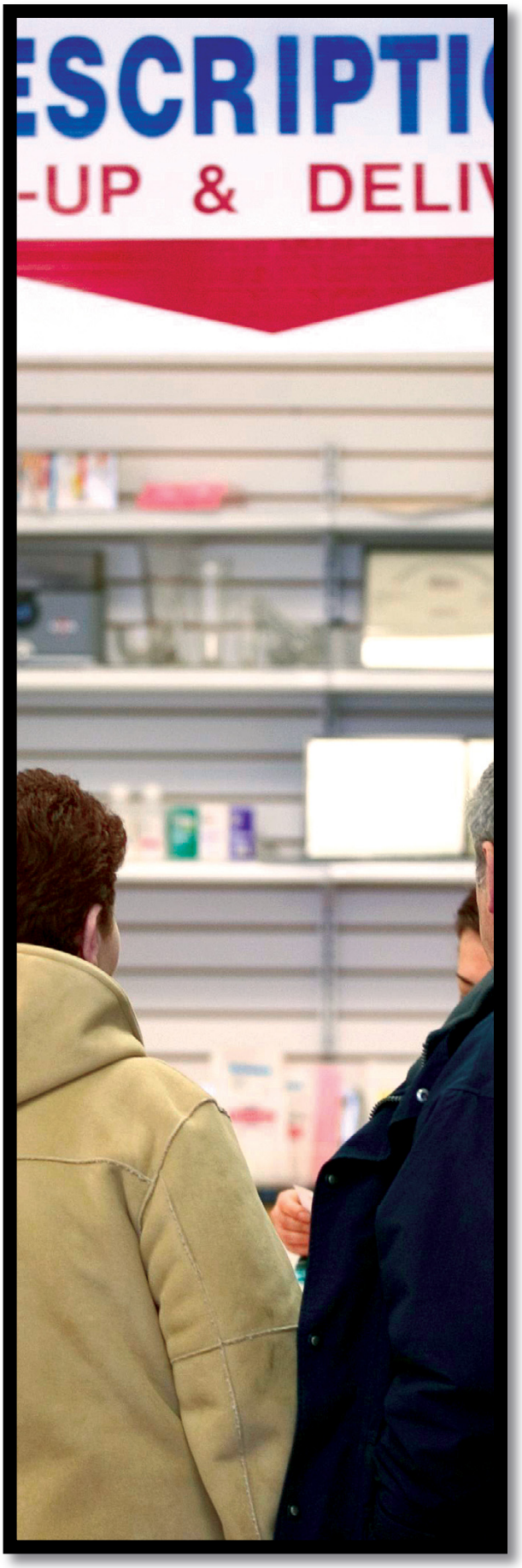
Leveraging Pharmacy Benefit Management Contracts

To the extent that they are not prohibited from doing so, state agencies and systems should be encouraged to regularly communicate their best practices about pharmacy benefit management (PBM) contracts with other state agencies and systems.

Agencies with multiple PBM contacts should periodically review them to ensure they are economical for their beneficiaries, and effectively and efficiently utilize state funds. With regard to a single PBM contract for state agencies, much attention has been dedicated to consideration of this issue. For example, a Joint Interim Report to the 80th Legislature, December 2006, by the Senate Committees on Health and Human Services and State Affairs explored the issue. More recently, a February 15, 2008, joint legislative hearing of Texas House of Representatives committees on Government Reform and Pensions and Investments was conducted to evaluate and make recommendations regarding state contracts with PBMs. The Council's staff has explored this issue, with input from the Council's Pharmaceuticals Workgroup (CPW) members. The State Auditor's Office also issued a report on the topic in August 2008[1]. The Council's assessment of the issue has determined that a single PBM contract for state agencies would ultimately prove detrimental to the state. Market-based competition would be stifled and agencies would not be allowed to benefit from the advantages and lessons learned from the negotiation of other state PBM contracts.

Continued Coordination of State Agency and System Purchasing Practices

Enhance the CPW establishing two separate sub-workgroups under the auspices of the Council: (a) a group of state agencies that purchase pharmaceuticals either directly and indirectly; and (b) a group of state academic systems that purchase pharmaceuticals. While the CPW has wide representation from state agencies, just one academic system is represented. State agencies have had the opportunity to learn from each other by sharing best practices and information; the same opportunity exists for academic systems.



1 "Report No. 08-042, An Audit Report on Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions." *State Auditor's Office*. August 2008. 12 Dec. 08 < http://www.sao.state.tx.us/reports/main/08-042.html>.

Require Agencies that Indirectly Purchase Pharmaceuticals Through PBMs to Share Contract Information

The Council recommends legislation be filed that (a) would require state agencies and systems to negotiate re-procured or newly created contracts that do not prohibit the sharing of pricing information between state agencies and systems; and (b) maintains and protects the confidential nature of that information.

The Council has explored several options state agencies and systems might pursue to optimize the purchase of pharmaceuticals. Among these options are some recurring themes, which include the following.
State agencies and systems can learn from each others' purchasing strategies and practices.

- Each agency and system has unique considerations for its populations, programs, and where applicable, contracts.
- Maintaining and enhancing pharmaceutical purchasing options for state agencies, systems, and ultimately beneficiaries and consumers – as opposed to limiting those purchasing options – can serve to stimulate competition and preserve consumer choice.
- Texas' large size, and thus purchasing volume, makes it difficult to justify efforts to join with other states to enhance this already-existent purchasing advantage.
- Opportunities exist to enhance, refine, or augment pharmaceutical purchasing strategies. Depending on state agency and academic system needs, some or several of these strategies may be applicable.
- Several state agencies enhance purchasing power by engaging in group purchasing contracts. Academic systems may be able to benefit from similar cooperative purchasing arrangements.

This report makes several recommendations about how to optimize pharmaceutical purchasing while preserving purchasing methods and strategies that benefit the agencies and the systems that utilize them. Options that may prove advantageous or detrimental to the state are also presented.

Overall, the state agencies and academic systems of Texas must weigh several criteria, some of which are unique, before procuring pharmaceuticals and services. Continued vigilance about how to ensure economically efficient and therapeutically sound purchases must be maintained.

I. Introduction

States are concerned about controlling ever-growing costs for health care expenditures. Among these concerns is controlling expenditures for pharmaceuticals. Since July 2006, the Texas Health Care Policy Council (the Council) has considered options to reduce or control future costs of state prescription drug purchases. These considerations are consistent with the statutory charge to the Council to ensure the most effective collaboration among state agencies in the purchase of health care products or services.

The Council is one of several entities that have considered the issue of how to contain state expenditures for pharmaceuticals. Legislation and legislative interim reports[2] have been dedicated to the issue, as has the Legislative Budget Board in their own reports[3]. Additionally, an Interagency Council on Pharmaceuticals Bulk Purchasing (ICPBP) was established by statute[4] to study the issue. The ICPBP was abolished in 2005, however its duties and responsibilities were assumed by the Council.

II. Purpose

This report is intended to serve as a resource guide to policy-makers. It provides information, considerations, conclusions, and recommendations regarding several pharmaceutical purchasing options. Recurring issues explored previously by committees, councils, and legislators, are addressed with updated information. Several additional optimization options are also examined.

III. Strategies

1. The Work of the ICPBP

Established in September 2001, the ICPBP explored the feasibility of joint purchasing opportunities between state agencies, as it was believed that bulk purchasing of drugs might reduce overall state spending. The ICPBP also examined purchasing strategies to ensure cost effectiveness of pharmaceutical purchases among all state agencies. As a result of this work, the ICPBP developed two sets of pharmaceutical purchasing procedures to promote interagency communication and cost containment: (1) one set for state agencies that purchase pharmaceuticals directly from manufacturers; and (2) another set for state agencies that purchase pharmaceutical services, e.g. through a pharmacy benefits manager (PBM) contract.

These two different purchasing strategies were necessary because not all state agencies purchase and utilize pharmaceuticals the same way. Some agencies [e.g., the Department of State Health Services (DSHS) and the Texas Department of Criminal Justice (TDCJ)] purchase their pharmaceuticals directly from manufacturers and then distribute those pharmaceuticals directly to their clients through their programs and services. Other state agencies [e.g., the Employees Retirement System of Texas (ERS)] contract with pharmaceutical benefit managers to secure negotiated prices for pharmaceuticals their plan participants purchase themselves from pharmacies.

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2 For example, the Senate Committee on Health and Human Services Senate Committee on State Affairs's, *Joint Interim Report to the 80th Legislature*, December 2006, Pharmacy Benefit Managers.

3 For example, the Legislative Budget Board's, *Improve the State's Management of Pharmaceutical Costs*, Staff Performance Report to the 79th Legislature, January 2005, pp. 21-29 and the Legislative Budget Board's *Comparison of Cost Savings Measures of State Employee Health Plans*, Texas State Government Effectiveness and Efficiency, January 2007, pp. 109-119.

4 Texas Legislature. "House Bill 915, 77th Texas Legislature, Regular Session, 2001." Texas Legislature Online. 12 Dec. 2008. < http://www.legis.state.tx.us/tlodocs/77R/billtext/html/HB00915F.htm>.

The ICPBP also focused on developing a method to obtain comparative drug pricing information across state agencies. However, ICPBP efforts to compare drug prices were questioned and ultimately abandoned due to concerns by drug manufacturers that prices would not be confidentially reviewed and maintained by an entity subject to the Open Meetings Act. However, frustration remained about whether one state agency might be paying more for the same drug than another.

In January 2005, the ICPBP produced a report to the Texas Legislature in which it made a number of recommendations. One recommendation focused on whether a single, central pharmaceutical purchasing agency should be established, with the rationale that price and expenditure efficiencies might be obtained if one, and not all, state agencies dedicated time and resources to the endeavor. The recommendation, however, was that a central purchasing agency not be established. This recommendation may have been made because: (1) purchasing needs and methods vary between direct and indirect purchasers; and (2) there are agency-specific differences in populations served, distribution channels used, drug dosage requirements, and dispensing locations that typically require different purchasing and contracting methods that a central purchasing agency could not adequately address.

Other ICPBP report recommendations focused on how to optimize the statute that had created it so that some of the challenges it faced in meeting its designated charges could be more easily accomplished. However, the ICPBP was ultimately abolished and the charges and challenges faced by it were assumed by the Council. Currently, the Council's staff works closely with a Texas Health Care Policy Council Pharmaceuticals Workgroup (CPW) comprised of state agency representatives focused on pharmaceutical purchasing[5]. The CPW provides expertise and advice to inform the recommendations the Council makes to the Governor on pharmaceutical cost containment strategies.

5 CPW members include representatives from: (1) the DSHS; (2) the Department of Aging and Disability Services; (3) the Health and Human Services Commission; (4) the Texas Youth Commission; (5) the Texas Criminal Justice Division; (6) the ERS; (7) the Teacher Retirement System of Texas; and (8) the University of Texas System.

2. Survey of Current Pharmaceutical Purchasing Strategies

To determine how best to focus the efforts of the Council in assuming the duties and challenges of the ICPBP, the Council's staff sought to understand which measures state agencies and university systems currently practice to ensure effective and efficient purchasing of pharmaceuticals and services that were appropriate for their respective populations, programs, and facilities. The Council's staff conducted a survey to:

- Assess which strategies state agencies and university systems currently utilize, and do not utilize, to optimize pharmaceutical purchasing.
- Utilize responses to best target future optimization endeavors.
- Identify opportunities for inter-agency collaboration.

Surveys were sent to the CPW member organizations and all university systems represented on the Council[6]. Staff received 19 responses, which included information provided not only by agencies and university systems, but also by some affiliated health science centers, dental schools, hospitals, clinics, The University of Texas M.D. Anderson Cancer Center, and The University of Texas Southwestern Medical Center at Dallas.

The survey sought information about five main themes:

1. Pharmaceutical purchasing requirements (i.e. programs and services);
2. Pharmaceutical expenditures for fiscal years (FY) 2005-2007;
3. Methods utilized to control spending;
4. Recommendations for strategies the state could pursue to optimize purchasing; and
5. Recommendations or other comments the Council should consider with regard to pharmaceutical purchasing.

Pharmaceutical Purchasing Requirements

Information provided in response to these questions helps to determine the different pharmaceutical purchasing obligations incurred by the state. The survey provided additional evidence that there is a clear distinction between agencies and entities that purchase drugs directly (e.g. DSHS, health science centers) and those that do not [(ERS), Teacher Retirement System (TRS), Medicaid]. It also became clear that each agency has distinct populations, federal program obligations (where applicable), and pricing considerations that make comparisons among them challenging. For university systems, employee group insurance plans (where applicable), health science center, and hospital pharmaceutical purchasing obligations were identified.

6 University systems included on the Council include: (1) Texas A&M University System; (2) The University of Texas System; (3) Texas State University System; (4) Texas Tech University System; (5) University of Houston System; and (6) University of North Texas System.

Pharmaceutical Expenditures

To get a sense of how much state general revenue was utilized to purchase pharmaceuticals, respondents were asked to report FY 2007 expenditures. FY 2007 expenditures for all agencies and systems were over $2.2 billion. However, this number should be regarded cautiously and the following considerations should be kept in mind.

- This total represents surveyed and responding agencies and systems. Thus there may be additional spending that occurs that was not captured by the survey instrument.
- The total does not include expenditures for The University of Texas System (UT System) or Texas A&M Employee Group Insurance Plans, as there was no explicit survey question seeking this information.
- The total represents state expenditures only and does not include federal spending for pharmaceutical purchases in the same year for Texas beneficiaries. For example, the Medicaid program receives federal funding for its Medicaid and the Children's Health Insurance Program (CHIP); some programs at DSHS receive federal funding from the Centers for Disease Control and Prevention.
- The total also does not take into account co-pays, premiums, or deductibles paid by recipients. Thus, total pharmaceutical expenditures for Texas beneficiaries in FY 07 exceed the total represented above.

In an effort to refine the information on expenditures, agencies and university system employee group insurance plan participants on the CPW were asked additional questions. These questions broadened the scope of the inquiry by seeking both general revenue and all drug cost expenditures for FYs 2005-2007.

Complete information is only available for all drug costs; some agencies do not have general revenue stipulated separately from other funding sources. For all three fiscal years, all drug costs for all reporting entities averaged to $2.5 billion per year. However, between 2005 and 2007, the total of all drug costs decreased. This may be attributable to the institution of the Medicare Part D Retiree Drug Subsidy Program.

Methods Utilized to Control Spending

Respondents were asked to list the methods they currently utilize to control spending (e.g. 340B program, rebates, prior authorization). Amongst all of the respondents, 48 methods were identified. However, it should be noted that not all methods are applicable to all agencies and entities. As was apparent from previous questions, there are clear distinctions between those that purchase drugs directly and those that do not.

When focusing on the agencies and university system employee group insurance plan participants on the CPW, there are some methods they all utilize, which include:

- Drug utilization review;
- Utilizing edits and audits;
- Utilizing a formulary;
- Encouraging generic substitution; and
- Utilizing a preferred drug list.

Recommended Strategies for Optimized Purchasing

Responses to this question ranged from agency-specific initiatives (e.g. implement additional pharmacy assistance programs for agency programs) to those that spanned across agencies (e.g. develop best practices that can be shared).

Other Recommendations or Comments

Responses to this question provided thoughts about intended, and unintended, consequences for various pharmaceutical purchasing optimization methods.

- Additional mandates or regulation can inhibit market-based competition.
- Bulk drug distribution and packaging is unlikely to be beneficial because of specific agency and program considerations.
- The needs of an acute care hospital differ from those caring for ambulatory patients with chronic diseases.

Overall Findings of the Survey

Consideration of the unique purchasing needs and obligations of various state agencies and systems should not be forfeited when considering how to optimize pharmaceutical purchasing. Opportunities exist for agencies and systems to learn from each others' purchasing strategies and practices. Continued dialogue between state agencies and systems should be encouraged and facilitated.

3. Drug Price Comparison

While the survey of current pharmaceutical purchasing strategies was helpful in determining how state agencies and systems optimize their purchasing, the survey did not address whether one agency or system might be paying a higher or lower amount for a drug than another. The Council's staff requested drug price comparison information from all CPW members to begin to determine if, where, and how purchasing differentials were occurring.

The following information was solicited for the top-100 most commonly prescribed drugs during the month of January 2008 at each CPW member agency or system.

- National Drug Code (NDC) number;
- Drug name;
- Strength (e.g. 10 milligrams);
- Form (e.g. tablet, capsule); and
- Price paid per unit[7].

For agencies that provide members with mail order and retail purchasing options (e.g. ERS, TRS, UT System), information was provided for both purchasing options. For agencies that provide pharmaceutical benefits to both active and retired populations (e.g. ERS and TRS), information was provided for both populations. Overall, the Council's staff received, analyzed, and compared 1,500 drug prices.

After initial analysis by the Council's staff, CPW members also assisted with data analysis. However, the Council's staff was restricted in how it could share drug price comparison information. While the CPW is not subject to the same limitations in exploring drug price comparison data as the ICPBP[8], it was still subject to privacy and confidentiality considerations for pricing information that was shared by agencies and systems that purchase their pharmaceuticals from a PBM. Agencies that purchase their drugs directly from manufacturers were not subject to confidentiality and propriety information restrictions, and thus the Council's staff and CPW members were not either. Therefore, when analyzing the data, CPW members from directly purchasing agencies (DSHS, Department of Aging and Disabilities Services, Texas Youth Commission, and TDCJ) were able see how their prices compared to other like-agencies. However, CPW members from indirectly purchasing agencies (Texas Health and Human Services Commission (HHSC), ERS, TRS, and UT System) were not able to see how their discounts compared to other like agencies. For these workgroup members, analysis and discussion focused on broad generalizations about the data.

Data Analysis Findings for Directly-Purchasing Agencies

- There are some significant price differences between forms of medication (e.g. tablet vs. oral solution) within the same agency.
- For the same drug, form, and strength of a medication, there may be several different NDC codes and prices.
- There were noticeable price differences between agencies for the same types of medications.

7 Any rebates due to state agencies were not factored into prices.

8 The Pharmaceuticals Workgroup is not subject to the Open Meetings Act.

Considerations

1. Note that prices provided by agencies may not all reflect the same time period. While January 2008 was specified in the data request, prices change daily. Additionally, prices may reflect purchasing prices at the time of purchase, which could have been several months prior to January 2008.
2. Forms of medication dispensed may reflect the preferences of particular program types, physicians, and patients. Utilization of only one medication type, for the sake of purchasing optimization, would prove limiting.
3. Several different NDC codes and prices indicate different manufacturers are providing those medications.
4. Agencies may use the same drugs, but have different prices for those drugs depending on which populations they serve and pricing advantages they secure for their programs.
5. Package sizes have different prices: more pills in a package usually equates to higher prices.
6. An agency may need multiple package sizes, as facilities and programs have different needs.
7. Price differences across agencies reflect the different purchasing methods used to procure them (e.g. 340B program pricing or group purchasing organization pricing advantages). Not all agencies are able to receive the same types of pricing advantages as another.

Data Analysis Findings for Indirectly-Purchasing Agencies

- ✯ Note that prices provided by agencies may not all reflect the same time period. While January 2008 was specified, prices change daily. Additionally, prices may reflect purchasing prices at the time of purchase, which could have been a few weeks prior to January 2008.

Retail Sale of Pharmaceuticals

- ✯ 290 distinct NDCs were identified as "in common purchases" across agencies.
- ✯ There was marked price differentiation between agencies among these NDCs.
- ✯ These price differentials are found within (e.g. between active and retired populations) and across agencies.
- ✯ Where NDC price differentials between active and retired populations were found (n=95), NDC prices for retired individuals were higher than NDC prices for active populations 72 percent of the time.
- ✯ Amount of NDC price differential between active and retired populations (n=95): 39 percent of the differential amounted to more than a $0.10 difference; 61 percent of the differential amounted to less than a $0.10 difference.

Mail Order Sale of Pharmaceuticals

- 263 different NDCs were identified as "in common purchases" across agencies.
- There was marked price differentiation between agencies among these NDCs.
- These price differentials are found within (e.g. between active and retired populations) and across agencies.
- Where NDC price differentials between active and retired populations were found (n= 74), NDC prices for retired individuals were higher than NDC prices for active populations 53 percent of the time.
- Amount of NDC price differential between active and retired populations (n=74): 34 percent of the differential amounted to more than a $0.10 difference; 66 percent of the differential amounted to less than a $0.10 difference.

Considerations

- When considering pharmaceutical pricing, the following should be considered:
  - Contracts;
  - Plan design;
  - Rebates;
  - Discounts; and
  - Guaranteed costs.
- It is important to keep in mind that pharmaceuticals are just one component of an overall group benefit health plan package.
- It is important to keep in mind that any perceived savings to the state regarding TRS's Active Care population must be regarded cautiously: the teachers' benefits in their group benefit plan are paid largely out of school budgets and out-of-pocket by the members themselves.
- It is important to keep in mind that prices can be renegotiated by the agency at any time during the lifetime of a contract.

Overall Findings of the Drug Price Comparison Analysis

While several prices for the same drugs were found across agencies and systems, it is difficult to apply the same cost considerations across all agencies and systems. Each agency or system has unique considerations for its populations, programs, and where applicable, contracts.

4. Mail Order and Retail Sales

Through the ERS, TRS, and UT and Texas A&M systems, plan members currently have a choice about how to purchase their pharmaceuticals. While mail order options typically provide lower-cost medications with up to a 90-day supply, retail purchasing offers convenient and personalized service. Because mail order purchasing is more economical for both plan members and ultimately for the state, some have suggested that mail order purchasing should be mandatory.

Considerations of Mail and Retail Sales

- Mail order pharmacies dispense drugs at a substantially lower total cost (i.e. for the state and plan member) than at a retail pharmacy.
- On average, both brand-name and generic drugs cost less at mail than at retail because of the deeper discount and the absence of a dispensing fee at mail.
- Plan members usually pay a higher co-payment amount for retail maintenance drugs than they do for mail order maintenance drugs.
- Plan members appreciate the convenience of using mail order for their maintenance drugs.
- Plan members also need access to acute, immediate need medications through the retail network.

Overall Findings for Mail Order and Retail Sales

Because of the diversity of populations, needs, and preferences across the state, retaining both mail order and retail sale options would preserve plan members' ability to make choices about how they wish to pursue the purchase of their pharmaceuticals.

5. Multi-State Drug Purchasing Pools

The idea of Texas joining with other states to optimize purchasing volume to maximize cost efficiencies has been considered for several years. Discussed below are two multi-state drug purchasing strategies.

A. Medicaid Multi-State Drug Purchasing

In March 2007, HHSC submitted a report[9] on Medicaid multi-state drug purchasing to the Texas Legislature, which included analysis of three different purchasing pool agreements: (1) The National Medicaid Pooling Initiative (NMPI), which includes Alaska, Hawaii, Kentucky, Michigan, Minnesota, Montana, Nevada, New Hampshire, New York, and Tennessee; (2) The Optimal Preferred Drug List (PDL) Solution (TOP$), which includes Delaware, Idaho, Louisiana, Maryland, Wisconsin, and West Virginia; and (3) the Sovereign States Drug Consortium (SSDC), which includes Iowa, Vermont, and Maine.

Texas currently receives rebates from drug manufacturers averaging 30 percent (which is considered favorable). HHSC was able to estimate that if it were to join either the NMPI or the TOP$ pools (confidential rebate information for analysis was not available for SSDC) that it could realize an additional annual savings of between $3.8 and $4.2 million in general revenue. The savings estimate assumes that the Texas Pharmaceuticals and Therapeutics (P&T) Committee would recommend, and HHSC would adopt, a PDL essentially the same as other member states.

The HHSC report also included brief analysis of the impact of Medicare Part D on the Texas PDL. Effective January 1, 2006, over 300,000 Medicaid recipients who were also eligible for Medicare no longer receive prescription drug coverage under the Texas Medicaid Vendor Drug Program (VDP), except for a very limited number of drugs excluded from the Medicare Part D program. Drug expenditures for these individuals were drastically reduced, which in turn caused the loss to the state of PDL supplemental rebates. Since one of the main goals of joining a multi-state purchasing pool is to pool together Medicaid populations to increase purchasing power and generate larger rebates and discounts from drug manufacturers, Medicare Part D limits states' abilities to do so because it decreases the populations eligible for pooling.

9 Analysis of Multi-State Medicaid Drug Purchasing Pools, Pursuant to the 2006-07 General Appropriations Act (Article II, Health and Human Services Commission, Rider 56, SB 1, 79th Legislature, Regular Session, 2005).

Considerations for Medicaid Multi-State Drug Purchasing

- Because states' PDLs vary, savings to Texas might be reduced to the extent that the Texas P&T Committee recommendations and the resulting PDL differ from other member states.
- If HHSC were to join a Medicaid multi-state purchasing pool, it would need to adopt a PDL essentially the same as other member states in order to maximize savings. Such an adoption may not be in the best interest of Texans because it may not be able to take into account Texas-specific considerations.
- There are several differences between Texas' and other states' PDL processes. For example, Texas law requires that a supplemental rebate be in place in order for a product to be on the PDL. Other states do not have this requirement.
- Texas' law requires the P&T Committee to hold quarterly meetings to consider PDL updates. States currently engaging in Medicaid multi-state drug purchasing agreements meet less frequently. If Texas were to join a Medicaid multi-state drug purchasing pool, it is likely the applicable statute would need to be changed to bring its P&T Committee schedule in accord with other states' schedules.
- Texas law requires that supplemental rebates be based on the Average Manufacturer Price (AMP) for each specific drug. Both NMPI and TOP$ have supplemental drug agreements that are based on Wholesale Acquisition Cost (WAC). WAC does not represent an actual transaction price and does not include prompt pay or other discounts, rebates, or reductions in price.
- The Deficit Reduction Act of 2005 required the Centers for Medicare and Medicaid Services to promulgate a regulation that clarifies the requirements for, and manner in which, AMPs are determined. These changes affect pharmaceutical pricing structures in all states.
- Other states: In 2007, Colorado was the only state to address Medicaid multi-state purchasing pools; it did so through an executive order. However, the main goal of the executive order was to establish price control mechanisms that Texas currently utilizes (e.g., establishment of a PDL and a Texas Pharmaceuticals and Therapeutics Committee). The brief mention of multi-state purchasing in the executive order was to explain that establishment of a PDL would make the state eligible to join a multi-state purchasing pool.

B. Other Multi-State Purchasing Pool Options

In addition to the possibility of exploring the feasibility of Medicaid multi-state purchasing pools, there are other types of pools to consider. For example, West Virginia and other, smaller states (Missouri, New Mexico, Delaware, and Ohio) pooled pharmaceutical purchasing for their public employees to create Rx Issuing States (RxIS). West Virginia also included its State Children's Health Insurance Program enrollees in this drug purchasing pool.

In deciding to pool their eligible populations, participating RxIS states sought to change their drug purchasing arrangement of paying PBMs small administrative fees with the PBMs retaining the bulk of the rebates from drug manufacturers (states discovered that what they had been receiving in rebates from manufacturers amounted to only about 3-5 percent of their total drug spending). The states issued a Request for Proposals stipulating that they would benefit from the full rebate. They then selected a PBM that agreed to an Administrative Services Only-type arrangement whereby the states would pay higher administrative fees but would receive all of the manufacturers' rebates.

Considerations for Other Multi-State Purchasing Pool Options

- It is unclear if the benefits reaped from the pooled populations of smaller states (RxIS = 700,000 beneficiaries) would benefit a state like Texas, which already has a large population pool and existing PBM contracts that serve it.
- The administrative fees paid in the RxIS pool were based on a sliding scale that correlates to the pool's volume: the greater the number of covered lives, the lower the per-unit administrative costs.
- Challenges for multi-state pools include navigating multiple state regulations and political interests; dedicating the time and will necessary to conduct analysis and negotiations necessary to determine if savings can be achieved; and executing a sound contract to deliver the identified savings.
- In August 2002, ERS reviewed a sample RxIS contract and compared it to its own contract. The analysis indicated that the ERS contract was more favorable in the areas of administrative fees, formulary management fees, mail services, rates, rebates, and disease management fees.
- The RxIS venture was ultimately terminated in 2005. Negotiation with other states regarding adequate PDLs for their populations is what posed the greatest challenge.

Overall Findings for Multi-state Drug Purchasing Pools

Because of its large size and purchasing volume, it is unlikely that Texas would benefit from joining with other states to reduce Medicaid VDP expenditures. Furthermore, if Texas were to join its Medicaid VDP purchasing with other states, it would be compelled to make statutory changes that would ultimately compromise the program's high standards for its purchasing review and decision-making. In the event these changes were agreed to and made, it is unlikely Texas would achieve any improvement to the Medicaid VDP or realize any cost savings.

As for pooling pharmaceutical purchasing for Texas public employees with other states' public employees or programs, several compromises and considerations must be carefully weighed and negotiated amongst several states to be considered beneficial to all participants. The RxIS experience demonstrates that this approach was ultimately unsuccessful. Again, Texas' large size (i.e. high purchasing volume) makes it difficult to justify the effort required to join with other states to achieve what most would consider a labor-intensive compromise that has a high likelihood of failure.

6. 340B Drug Pricing

The 340B Drug Pricing Program provides pharmaceutical purchasing advantages and cost savings to some, but not all, Texas state agencies. Not all agencies participate because not all qualify for the program.

The 340B Drug Pricing Program requires pharmaceutical manufacturers participating in Medicaid to enter into a second agreement with the federal government to provide additional, negotiated discounts on drugs purchased by certain government-supported facilities, referred to as "covered entities," serving vulnerable populations on an outpatient basis (thus 340B pricing advantages are not applicable to inpatient hospital services). The program permits eligible covered entities [e.g., federally qualified health centers, disproportionate share hospitals (DSH)] to contract with external pharmacies to provide pharmacy services to patients of those covered entities. Current guidelines allow each entity site to contract only with a single pharmacy for services.

A number of pharmaceutical providers in the Medicaid VDP currently receive 340B pricing, including DSH clinics and pharmacies that specialize in hemophilia treatment. TDCJ is able to receive 340B pricing for most prisoners because health care in the majority of Texas prisons is provided by the University of Texas Medical Branch, which is considered an eligible covered entity because it is a DSH. The NorthSTAR program also utilizes 340B program pricing for non-Medicaid enrollees for mental health medications. Additionally, Title V (Maternal and Child Health Services Block Grant), Title X (Grants to States to Aid the Blind) and Title XX (Block Grants to States for Social Services) family planning co-op program contractors also use 340B pricing or negotiated discounts.

Pricing discounts through the 340B program are not only limited to covered entities, they are also limited to specific "patients." The 340B program requires drugs purchased under the program to be used only for individuals who are patients of the covered entity that purchased the drugs. A patient must: (1) be treated by a health care provider that is directly employed or contracted by a covered entity; (2) have his/her medical record utilized by the covered entity; and (3) receive services in a manner in which they are considered the responsibility of the covered entity. In general, drugs purchased under 340B are not also subject to Medicaid rebates. However, current supplemental rebates raise Medicaid discounts to near 340B discounts.

Overall Findings for the 340B Drug Pricing Program

Agencies and programs that qualify for 340B pricing advantages should be encouraged to pursue participation in the program. Additionally, qualifying agencies should be encouraged to partner with non-qualifying agencies to expand overall 340B pricing advantages to the state when it is clear the advantages for doing so (e.g. increased savings to the state) would outweigh disadvantages (e.g. compromised patient care or forfeiture of existing pharmaceutical contracting advantages).

7. State Pharmaceutical Assistance Programs

State Pharmaceutical Assistance Programs (SPAP) provide another opportunity for some, but not all, state agencies to achieve pharmaceutical purchasing advantages. A SPAP is a non-Medicaid program operated by a state that provides financial assistance to select beneficiaries for the purchase of prescription drugs. Federal law allows SPAPs to negotiate prices for drugs below Medicaid Best Price levels. Individuals covered by SPAPs may not have any other drug coverage and cannot be eligible for Medicaid. To qualify as an SPAP under federal enabling legislation, a state program may not be funded with any federal funds.

Under the legal authority of federal law, the definition of SPAP allows certain limited-function state programs to be treated as "Qualified SPAPs." Usually these programs are limited to individuals with a single diagnosed condition, and often provide benefits beyond just pharmaceuticals. The Texas Kidney Health Care Program is considered a Qualified SPAP.

With the advent of the Medicare Part D program in January 2006, several state programs around the country ceased SPAP operation because their plans were replaced (e.g. Florida, Kansas, Michigan, Minnesota, and North Carolina). Most states that had been paying nearly 100 percent for drug subsidies chose to shift some or all of their programs to provide a supplemental or "wrap around" benefit so that Medicare-eligible enrollees would receive primary coverage through the Medicare Part D Prescription Drug Plan. These states converted their efforts to "secondary, wrap-around" coverage, most often paying for some, or all, of the required enrollee share of monthly premiums, co-insurance or co-payments, annual deductibles, or the "gap" or "doughnut hole."

The wrap-around strategy allows states to combine a set of federally-funded benefits with another package of state-funded benefits. Medicare-eligible Texas Kidney Health Care Program recipients currently receive drug coverage through the Medicare Part D program with wrap-around benefits for Medicare Part D premiums, deductibles, and co-insurance above the subsidized amounts, for drugs on the Kidney Health Care formulary and the Medicare Part D plan formularies.

The DSHS recently developed the Texas HIV SPAP to assist with Texas HIV Medication Program (THMP) for clients concurrently enrolled in Medicare with the out-of-pocket medication costs associated with Medicare Part D prescription drug plans. The state agency issued a Request for Proposals designed to identify a PBM to provide Medicare Part D cost sharing assistance via a SPAP for clients with incomes between 135 and 200 percent of the federal poverty level enrolled in THMP, also known as the AIDS Drug Assistance Program for the state. The program became effective in November 2007.

In the December 2006 Council policy paper, *Improving State Pharmaceutical Purchasing in Texas*,[10] it was suggested that additional state programs might qualify for SPAP status. Suggested programs included: (a) community mental health/mental retardation centers; (b) county indigent health care programs; and (c) primary health care services. This paper also suggested that total annual general revenue SPAP savings for community mental health centers might be approximately $6.0 million.

10 State of Texas. Texas Health Care Policy Council. "Improving State Pharmaceutical Purchasing in Texas." Office of the Governor. Dec 2007. 12 Dec. 2008 <http://governor.state.tx.us/thcpc/resources>.

A. Community Mental Health Centers

In February 2007, the Center for Pharmacoeconomic Studies at The University of Texas at Austin produced a report titled "A Comparative Evaluation of the Potential Cost Savings Realized by a State Pharmacy Assistance Program (SPAP) for Community Mental Health Centers in Texas."[11] This report was produced to provide assistance to DSHS to help the agency quantify the benefits and costs of developing a SPAP to coordinate mental health drug purchasing across participating community mental health centers in Texas. Potential benefits would include increased purchasing power, which would translate into lower drug acquisition prices. Potential costs would include decreases in current levels of Patient Assistance Program (PAP) assistance, the free medications provided by pharmaceutical companies that help to keep drug acquisition costs down for community mental health centers. With this in mind, the report assumed that manufacturers would not be likely to be as generous with their PAP donations if they also made greater pricing concessions at the system level through an SPAP.

A total of 21 community mental health centers provided data for the study; these centers represented 69 percent of all community mental health center patients in 2006. Analysis was based on the top 200 drug products (based on total payments) across all centers. To compare benefits and costs to actual community mental health center expenditures for drugs, various prices, and benchmarks were estimated, including:

- Estimate Method 1: *Medicaid Retail Pharmacy Rate* (which is the average Texas Medicaid Vendor Drug product unit payment for each drug);
- Estimate Method 2: *Medicaid Best Price Payment Rate,* a discounted Medicaid Retail Pharmacy Rate of 24 percent less for brand-name drugs and 8 percent less for generic drugs; and
- Estimate Method 3: *Replacement Unit Cost* for each PAP drug dispensed, which is based on the unit price each center would have actually had to pay for the drug had the manufacturer not provided the drug free of charge.

11 Johnsrud, Michael, and M Lynn Cismon. "A Comparative Evaluation of the Potential Cost Savings Realized by a State Pharmacy Assistance Program (SPAP) for Community Mental Health Centers in Texas." Center for Phamacoeconomic Studies, The University of Texas at Austin. February 2007.

- The study did not examine hypothetical SPAP price comparisons for current expenditures (i.e., whereby prices obtained for drugs would be negotiated to be below Medicaid Best Price levels).
- The evaluation determined that drugs provided by manufacturer PAPs accounted for nearly one-third of all prescription drugs dispensed across community mental health centers in 2006 and that across centers there is a high degree of purchasing power variability.
- Using the estimate methodologies devised for the study it was determined that:
- When drug payments were compared between what centers actually paid for drugs and what the *Medicaid Retail Pharmacy Rate* (Estimate Method 1) could have paid for those same drugs, actual payment rates ranged from a high of 12 percent above the Medicaid Retail Pharmacy Rate, to a low of 19 percent below the rate.
- When the evaluation compared the *Medicaid Best Price Payment Rate* (Estimate Method 2) to actual expenditures for all drugs utilized (and also assumed no PAP assistance), savings of 17.3 percent ($8.2 million) were estimated.
- Utilizing the *Replacement Unit Cost* (Estimate Method 3) for each PAP dispensed could represent a reduction of 48.3 percent ($23.0 million) in expenditures to community mental health centers

Considerations for a SPAP for Community Mental Health Centers

- The high degree of purchasing power variability among community mental health centers for pharmaceuticals suggests that they might benefit from a group purchasing arrangement.
- The University of Texas evaluation suggests that a strategy utilizing both PAP assistance and Medicaid Best Price Payment Rates may be the best way to achieve savings for drugs purchased by community mental health centers.
- The study did not directly address potential SPAP pricing advantages. To the degree that an SPAP could achieve prices lower than Medicaid Best Price Payment Rates, savings could be greater.
- It is unclear to what degree pharmaceutical manufacturers would continue to offer PAPs to patients if they also offered price concessions under a Medicaid Best Price Payment Rate scenario or lower SPAP rates.
- If PAP utilization was discontinued entirely, community mental health centers would need to achieve additional discounts of 37.5 percent below Medicaid Best Price to realize the savings currently provided by PAPs. It is unclear if a SPAP pricing strategy would achieve pricing advantages of 37.5 percent.

- If community mental health centers were able to negotiate additional purchasing agreements using the Medicaid Best Price scenario, community mental health centers would need to maintain at least 64.1 percent of their PAP utilization to realize the current level of savings achieved under PAP programs alone.
- If an SPAP strategy was not utilized, it is likely that a combination of additional price discounts like the Medicaid Best Price Payment Rate and further PAP program utilization would need to be maintained to achieve savings.
- Any proposed group purchasing arrangement may potentially affect PAPs offered by manufacturers.
- Other states: The Council's staff is not aware of other recent state activity related to SPAPs.

B. County Indigent Health Care Program

The County Indigent Health Care Program (CIHCP) is intended to ensure that needy Texas residents who do not qualify for other state or federal health care assistance programs receive health care services. Counties, public hospitals, and hospital districts administer the program. State law[12] requires that counties provide stipulated basic health care services. The same code states that public hospitals and hospital districts "shall endeavor" to provide basic health care service. Due to the ambiguous nature of which services public hospitals and hospital districts are required to provide, indigent health care services provided across the state vary from hospital district to hospital district and from public hospital to public hospital.

State law stipulates that counties are required to provide basic health services that include prescription drugs and immunizations, and may qualify for state assistance funds after they expend eight percent of their general revenue tax levy (GRTL); they may close their programs for the remainder of the state fiscal year if they expend eight percent of their GRTL and state assistance funds are unavailable. Many large metropolitan counties spend much more than eight percent of their GRTL through separately funded hospital districts and provide health care to individuals well above the 21 percent of the federal poverty level established for counties.

Not only is there a disparity between counties, public hospitals, and hospital districts as to which services they provide, there is also a disparity regarding eligibility criteria for the programs, funding or financing, reporting, and monitoring. Where a person resides in Texas can determine his or her level of access to health care services. The enabling statute for the CIHCP did not address or grant enforcement authority to the state to review CIHCP, nor did it require reporting of county programs unless a county is requesting state assistance funds. Per a September 2006 Indigent Health Care Advisory Committee Report of Recommendations[13], only 37 percent of entities involved in the CIHCP report their indigent spending and client information. And over the past several years, an average of 20 counties out of 142 county-run programs (14.1 percent) have spent over eight percent of their GRTL and received state assistance funds.

12 Chapter 61 of the Texas Health and Safety Code.

13 Indigent health Care Advisory Committee Report of Recommendations." September 2006, pursuant to Senate Bill 44, 79th Legislature, Regular Session, 2005.

Considerations for a SPAP for the County Indigent Health Care Program

- A lack of uniformity in CIHCP services among various providers makes changes, even if intended to be improvements, to the program challenging.
- Until there is more uniformity in program services and their delivery, it would be difficult to impose a system-wide cost-containment strategy like an SPAP.
- Without adequate and sufficient data, reporting, and monitoring, it would be difficult to determine if an SPAP would be beneficial.

C. Primary Health Care Program

The Primary Health Care (PHC) program serves women, children, and men whose income is at or below 150 percent of the federal poverty level and who are unable to access the same care through insurance or other programs. The six priority services provided are diagnosis and treatment, emergency services, family planning, preventive health services, including immunizations and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services. Secondary services include prescription drugs. DSHS helps fund nearly 137 clinic sites across the state by contracting with private health care providers. Other financial support for the program comes from local government associations, health professional organizations, religious organizations, citizen coalitions, and consumers.

Considerations for a SPAP for the Primary Health Care Program

- Not all PHC-contracted health care providers provide prescription drug services to their patients.
- It would be difficult to assess the benefit an SPAP would provide without knowing which PHC-contracted health care providers offered prescription drug coverage and to what extent those services were offered.
- Multiple funding sources for the PHC would make an assessment of whether an SPAP would be beneficial difficult to determine.
- Overall, prescription drugs are an important component of the PHC, but a small portion of the vast array of services that must be provided.

Overall Findings for SPAPs

For Community Mental Health Centers, it is highly likely that if an SPAP strategy were utilized, PAP discounts offered by manufacturers would be jeopardized. It is unclear to what extent manufacturers would lower their discounts, but it is possible that community health centers would not be able to recapture the same level of savings if they also utilized SPAP strategies.

For the CIHCP, because of the variability in the program, and too many counties that do not report activity, there appears little advantage to imposing this pricing strategy on this program.

For the Primary Health Care Program, because of the variability in the programs, and the small percentage of expenditures dedicated to pharmaceuticals, there appears little advantage to imposing this pricing strategy for this program.

8. Reverse Auctions

A reverse auction is an online procurement process that enables vendors of commodity items to bid against one another in real time to sell their products. Under this model, the buyer sets a top price for items and pre-qualified vendors compete against one another to lower their price to secure the business. The goal of reverse auctions is to drive prices down (instead of up, as is the case with conventional auctions) by facilitating competition between vendors. Winners, however, are not necessarily the lowest bidders; there are several criteria that must be weighed to ensure desired products are procured.

The reverse auction process has shown significant procurement savings in Texas and other states for standardized commodities (e.g. cement), and could be set up to award multiple winners. As pharmaceutical contracts expire and are re-procured, reverse auctions could be considered to secure lower procurement costs.

Considerations for Reverse Auctions

Procurement Process

During the "traditional" procurement process, there are three criteria agencies utilize to select a contractor for an agreed upon price.

1. Pricing – the agency evaluates and compares bids to Requests for Proposals received. In the case of pharmaceuticals, a bid would most likely consist of a percentage discount off of the Public Health Service price schedule, prices that are typically between 10 and 70 percent below average wholesale prices. Requests for Proposals typically provide a long list of "typical" drugs at a "typical" volume so bidders all can have the same sense of the magnitude in kinds and size of what the need is and thus what they are bidding on. This criterion is usually the easiest of the three to assess.
2. Scoring of the rest of the proposal – the agency evaluates the service terms, capacity to respond, measures of solvency, financial assurances, and other criteria not directly related to price.

3. Negotiation – the agency engages the potential contractor in discussions once the best applicant is identified based on the above criteria. This is when the value of service for pricing is balanced and the actual bid is finalized. The finalized cost is typically not the same cost that was presented to the agency when the contract was initially bid by the vendor. Only after all of the procurement criteria have been evaluated and negotiated can a valid value (i.e. price) for the services be ascertained by the agency.

A reverse auction process would evaluate bids on just one of these three criteria, pricing. In the case of pharmaceuticals, the best price is not an indicator of the best value. Quality service and adequate access to necessary products are considerations that take on great import; the pharmaceutical industry and the necessities and delivery of care are highly unpredictable. Evaluation of how a contractor responds with regard to reliable delivery of pharmaceuticals, especially in an emergency, must be a high priority. In addition, products garnered by a reverse auction may pose therapeutic limitations for which providers will not be comfortable.

Procurement Costs

There is no additional cost to agencies when pursuing "traditional" procurements. There is also no additional cost to agencies when engaging in reverse auctions. The Comptroller's Office provides reverse auctioning services, which charges vendors a variable percentage (up to two percent) for procurement costs. However, vendors usually pass the cost of this service on to agencies by either raising their prices or not offering as large a discount percentage.

Applicability of the Process to Pharmaceuticals

Many of the pharmaceuticals purchased by state agencies and systems are provided by sole-source manufacturers (i.e. the products are brand-name patent drugs that are not available generically). Thus, there would be just one company able to bid on the business. Reverse auctions are best utilized when several vendors can compete, which would not be possible if sole-source (i.e., "brand name") drugs were to be procured. While generic drugs might provide an opportunity for more bidders to participate in a reverse auction process, agencies currently garner several pricing advantages (e.g. 340B, Public Health Service pricing) for generics (and brand-name drugs, too) that are unique to their populations and programs.

Applicability of the Process to Pharmaceutical Supplies

Reverse auctions may be beneficial in the procurement of pharmaceutical supplies. Unlike pharmaceuticals, these items are less prone to variances that either are dictated (by diagnosis) or preferred (by a practitioner). These items are more amenable to the reverse auction model because several vendors could compete for the supply of the items.

Overall Findings of Reverse Auctions

Reverse auctions work best for the procurement of standardized commodities produced by several vendors. This purchasing model has limited applicability to sole-source (i.e. "brand name") pharmaceuticals because the goal of promoting vendor competition to drive down prices is not achievable. The model may, however, prove advantageous for the procurement of generic pharmaceuticals because more than one manufacturer is developing and selling these products. To be advantageous, several vendors should be able to compete for the business; depending on the generic product desired several vendors may, or may not, be available to participate. The procurement of pharmaceutical supplies may best utilize the reverse auctioning model. These items are less prone to variance, which means that several vendors may supply the desired product.

9. Leveraging Pharmacy Benefit Management Contracts

Each state employee health benefit plan sponsor (e.g. ERS, TRS, UT System, and Texas A&M University System) administers its own contracts for the management of pharmacy benefit programs for state employees. Some sponsors have more than one PBM contract. It may be possible to leverage these multiple, yet similar, PBM contracts to obtain lower prices and contain overall costs across state health benefit plan sponsors. Leveraging might mean:

a. Sharing best practices about PBM contracts;
b. Consolidating some state employee health benefit plan sponsor PBM contracts within agencies; or
c. Developing a single PBM contract to administer all state employee health benefit plan sponsor drug purchasing programs.

A. Sharing Best Practices About PBM Contracts

Information or expertise about PBM contracting garnered at one state agency could serve to benefit other state agencies, which could ultimately lead to reductions in pharmaceutical costs across state agencies.

Consideration for Sharing Best Practices about PBM Contracts

- ✯ Staff from state agencies and systems would need to regularly communicate their current practices with staff from other state agencies and systems to identify best practices.

B. Consolidating Some State Employee Health Benefit Plan Sponsor PBM Contracts Within Agencies

Some state agencies have more than one PBM contract for their beneficiaries. For example, TRS has two PBM contracts: (1) one for their actively employed beneficiaries; and (2) one for their retired beneficiaries.

Considerations for Consolidating Contracts within Agencies

- ✯ Differing beneficiary demographics and other considerations might make maintenance of more than one contract more economically beneficial than if only one contract was negotiated.
- ✯ In maintaining separate PBM contracts for different groups, beneficiaries comprising one risk group are not potentially burdened (e.g. by higher premiums) by the considerations for the other risk group. Keeping each group distinct means that each contract reflects a “similar” population, which serves to keep costs down for participants.
- ✯ As state agencies and university systems grow to meet the needs of their beneficiary groups, and as contracting practices may become more complicated to do so, it is possible that efficiencies might be gained by periodic review of those contracting practices.

C. Developing a Single PBM Contract to Administer All State Employee Health Benefit Plan Sponsored Drug Purchasing Programs

Pooling the beneficiary populations among all state agencies that purchase pharmaceuticals would increase purchasing volume, which may enhance negotiating power with PBMs and lead to reduced costs to the state for drugs.

Considerations for a Single PBM Contract

- Single PBM contracting could lead to increased savings for the state.
- While there would be only one PBM contract for all programs, it would still be possible for each program to offer different benefits, preferred drug lists, and prior authorization rules to its beneficiaries.
- Federal regulations for programs like Medicaid may affect considerations by other agencies and systems to participate due to the imposition of additional regulation.
- State agency and university system contracts for PBMs are all on different schedules and timetables, and are up for renewal at different times and years.
- Competition among PBMs to offer the best prices to state agencies may be lost if PBM contracts are bundled. This is because state agencies would not be able to benefit from others' negotiated and potentially better terms, conditions, and prices.
- Other states: Georgia implemented this type of initiative in 2000. The Georgia Department of Community Health (GDCH) contracted with a PBM to administer the pharmacy benefits for three GDCH plans and the Board of Regents plan. However, the program was dismantled in 2006 due to unresolved differences between participant populations, philosophies, and regulations. In their assessment of savings, Georgia stated most were derived from less expensive, albeit one-time, administrative fee services.
- The Council's staff is not aware of any other states that have attempted to implement a single PBM contract for all of their state agencies.

Overall Findings of Leveraging Pharmacy Benefit Management (PBM) Contracts

To the extent that they are not prohibited from doing so, state agencies, and systems should be encouraged to regularly communicate their best practices about PBM contracts with other state agencies and systems.

Agencies with multiple PBM contacts should periodically review them to ensure they are economical for their beneficiaries, and effectively and efficiently utilize state funds.

With regard to a single PBM contract for state agencies, much attention has been dedicated to consideration of this issue. For example, a Joint Interim Report to the 80th Legislature, December 2006, by the Senate Committees on Health and Human Services and State Affairs explored the issue. More recently, a February 15, 2008, joint legislative hearing of Texas House of Representatives committees on Government Reform and Pensions and Investments was conducted to evaluate and make recommendations regarding state contracts with PBMs. The Council's staff has explored this issue, with input from CPW members. The State Auditor's Office also issued a report on the topic in August 2008[1].

The Council's assessment of the issue has determined that a single PBM contract for state agencies would ultimately prove detrimental to the state. Market-based competition would be stifled and agencies would not be allowed to benefit from the advantages and lessons learned from the negotiation of other state PBM contracts.

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1 Report No. 08-042, An Audit Report on Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions.

10. Continued Coordination of State Agency and System Purchasing Practices

While the CPW has wide representation from state agencies, just one academic system is represented. State agencies have had the opportunity to learn from each other by sharing best practices and information; the same opportunity exists for academic systems.

Because of the diverse nature of pharmaceutical purchasing across state agencies and systems (e.g. direct and indirect purchasers), enhance the CPW by establishing two separate sub-workgroups under the auspices of the Council: (a) a group of state agencies that purchase pharmaceuticals; and (b) a group of state academic systems that purchase pharmaceuticals.

These sub-workgroups would regularly communicate with Council staff and continue to advise the Council's on pharmaceutical purchasing initiatives. Furthermore, each of these sub-workgroups would share best practices and explore options or opportunities to join together to enhance purchasing advantages. Sub-workgroups should do the following:

a. Analyze the State Auditor's Office Report No. 08-042, *Pharmacy Benefit Manager Contracts at Selected State Agencies and Higher Education Institutions*, and describe to the Council how recommendations made in the report can be instituted.
b. Meet at least twice a year as sub-groups and twice a year as an entire workgroup. These meetings should occur between July 2009 and throughout 2010.

Overall Findings of Continued Coordination of State Agency and System Purchasing Practices

Because of the diverse nature of pharmaceutical purchasing across state agencies and systems (e.g. direct and indirect purchasers), enhance the CPW by establishing two separate sub-workgroups under the auspices of the Council: (a) a group of state agencies that purchase pharmaceuticals either directly and indirectly; and (b) a group of state academic systems that purchase pharmaceuticals.

11. Require Agencies that Indirectly Purchase Pharmaceuticals through PBMs to Share Contract Information

Comparing prescription drug costs among state agencies and systems that provide pharmaceutical coverage through PBMs has posed challenges to the ICPBP, the Council, and to state agencies and systems themselves. Most are fairly certain that pharmaceutical costs are not the same across all state agencies and systems. Some negotiate more aggressive drug cost discounts than others. Manufacturers engage in strategic negotiations and marketing to ensure that the most appropriate contract and health care groups are best served by their products. These strategies are closely guarded by each manufacturer and are not commonly known.

Because pharmaceutical discounts comprise just one component of an overall prescription drug plan, it is important to consider plan design, rebates, discounts, and guaranteed costs (essentially the entire contract) when trying to compare prescription drug costs across agencies and systems. However, state agencies and systems are constrained in their ability to compare financial contract language because the information is considered proprietary and confidential by the PBMs. Currently, if a request for information regarding pharmaceutical pricing information related to a PBM is made of a state agency or system, that state agency or system refers the request to the Office of Attorney General (OAG) and notifies the PBM. The PBM has the option to raise objection to its release and provide argument to the OAG. The OAG rules whether the information is proprietary and confidential or subject to public disclosure. Even if, however, the OAG rules against the PBM, the PBM can sue to block release of the information until the matter is decided by the courts.

Texas Government Code §552.110 (Public Information, Exception: Trade Secrets; Certain Commercial or Financial Information) defines proprietary information for purposes of an exception to disclosure under the open records law:

a. *A trade secret obtained from a person and privileged or confidential by statute or judicial decision is excepted from the requirements of §552.021 (Public Information, Availability of Public Information, whereby public information is available to the public at a minimum during the normal business hours of the governmental body).*
b. *Commercial or financial information for which it is demonstrated based on specific factual evidence that disclosure would cause substantial competitive harm to the person from whom the information was obtained is excepted from the requirements of §552.021.*

Third parties, such as PBMs, might assert the exception under §552.110. If this exception is asserted and the OAG or a court agrees that the exception applies, then a state agency or system must treat that information as confidential as a matter of law. Under those circumstances, if a third party asserted the exception and a state agency or system released proprietary information to an unauthorized individual or entity, civil and criminal penalties for a state agency's or system's violation of the law may apply.

However, a PBM that asserts its information is proprietary can choose to disclose information at any time or waive the exception and not assert it initially; there would be no violation of law related to the PBM's disclosure of the information. To ensure confidentiality is maintained, state agencies and systems could sign confidentiality agreements that prohibit the disclosure of information to anyone other than those who would be specifically authorized to view it. The confidentiality agreement could prohibit publication or use of the information other than what would specifically be authorized by the agreement.

Alternatively, each state agency and system could include a provision in its contract with a PBM such that information could be shared, provided it remains confidential in the hands of the receiving state agencies or systems. This might be achieved on a voluntary basis. However, it is unclear how many state agencies or

systems would participate voluntarily (which would hinder the ability to achieve the desired goal). A statute authorizing or requiring sharing of information could serve as an alternative.

A PBM, however, may not be willing to enter into a contract with a state agency or system that allows that state agency or system to share its proprietary information with other state agencies or systems because it may perceive that the information in the hands of the receiving state agency or system will not be protected from release as zealously as it would in the hands of the state agency or system with which the PBM has the contract. If all state agencies and systems that provide their pharmaceutical coverage through PBMs shared contract terms and conditions with each other, the fact remains that each agency and system is responsible for programs and populations that are unique. It is unlikely that knowing what another agency or system's contract stipulations are would necessarily change another agency's or system's contract stipulations. What would be achieved by sharing this information is that everyone would be more fully informed to make rational economic choices.

Overall Findings of Requiring Agencies that Indirectly Purchase Pharmaceuticals Through PBMs to Share Contract Information

The Council recommends legislation be filed that (a) would require state agencies and systems to negotiate re-procured or newly created contracts that allow for the sharing of pricing information between state agencies and systems; and (b) maintains and protects the confidential nature of that information.

VI. Conclusions

The Council has explored several options state agencies and systems might pursue to optimize the purchase of pharmaceuticals. Among these options are some recurring themes, which include the following.

- State agencies and systems can learn from each others' purchasing strategies and practices.
- Each agency and system has unique considerations for its populations, programs, and where applicable, contracts. Maintaining and enhancing pharmaceutical purchasing options for state agencies, systems, and ultimately beneficiaries and consumers – as opposed to limiting those purchasing options – can serve to stimulate competition and preserve consumer choice.
- Texas' large size, and thus purchasing volume, makes it difficult to justify efforts to join with other states to enhance this already-existent purchasing advantage.
- Opportunities exist to enhance, refine, or augment pharmaceutical purchasing strategies. Depending on state agency and academic system needs, some or several of these strategies may be applicable.
- Several state agencies enhance purchasing power by engaging in group purchasing contracts. Academic systems may be able to benefit from similar cooperative purchasing arrangements.
- Texas Medicaid VDP standards and policies are exemplary; joining with other states in an effort to enhance purchasing power could compromise or jeopardize those standards and policies.
- A single PBM contract for state agencies and systems would stifle competition.

This report made several recommendations about how to optimize pharmaceutical purchasing while preserving purchasing methods and strategies that benefit the agencies and the systems that utilize them. Options that may prove advantageous or detrimental to the state were also presented. Overall, the state agencies and academic systems of Texas must weigh several criteria, some of which are unique, before procuring pharmaceuticals and services. Continued vigilance about how to ensure economically efficient and therapeutically sound purchases must be maintained.

December 8, 2008

The Honorable Rick Perry
The Honorable David Dewhurst
The Honorable Tom Craddick

Dear Governor Perry, Lieutenant Governor Dewhurst, and Speaker Craddick:

I am a member of the Texas Health Care Policy Council. I am also Foundation Professor of Law at the University of Houston Law Center and Co-Director of the Health Law & Policy Institute at the University of Houston. I agree with much of what is in the Council's report titled Optimizing Pharmaceutical Purchasing in Texas ("Pharmaceutical Purchasing Report"). There are three points in the report, however, about which I must express strong dissent.

1. *Requiring Agencies that Indirectly Purchase Pharmaceuticals Through PBMs to Share Contract Information (Pharmaceutical Purchasing Report page 28)*
   The Pharmaceutical Purchasing Report concludes: "The Council recommends legislation be filed that (a) would require state agencies and systems to negotiate re-procured or newly created contracts that allow for the sharing of pricing information between state agencies and systems; and (b) maintains and protects the confidential nature of that information." I agree with provision (a) but disagree with provision (b). Maintenance and protection of the alleged "confidential nature" of pharmaceutical pricing information infringes upon desirable transparency in government purchasing decisions involving hundreds of millions of dollars.

   A bill should be filed modifying §552.110 of the Texas Government Code to clarify that pricing information, including, without limitation, that contained in PBM contracts, shall be presumed not to be exempt from the requirements of Government Code §552.021 absent a showing by clear and convincing specific factual evidence (i) that release of such information would cause substantial competitive harm to the person from whom the information was obtained and (ii) that those harms would outweigh the benefits to the public from release of the information. Effective monitoring of agency performance generally requires that transparency be maintained in large purchasing decisions such as those involved in PBM contracts. There is no reason to presume that the public availability of such information would cause harm to Texas. There should be a strong presumption to the contrary.

2. *Leveraging Pharmacy Benefit Management Contracts (Pharmaceutical Purchasing Report page 25)*
   The report has not demonstrated that the disadvantages of a single PBM contract for state agencies would outweigh the advantages. The assertion that "market competition would be stifled" is not correct because competition of the sort Texas needs depends on the number of sellers of PBM contracts, not the number of buyers. A single PBM contract would not decrease the number of sellers of PBM services. It would reduce the number of purchasers somewhat, but this is precisely what is often desirable when negotiating against parties in a concentrated industry such as the PBM industry.

3. *Reverse Auctions (Pharmaceutical Purchasing Report page 23)*
   The case for reverse auctions for state procurement of generic pharmaceuticals and pharmaceutical supplies is even stronger than indicated by Council. Once qualified bidders are determined and other contract terms standardized, reverse auctions will generally most successfully reduce prices. I therefore recommend that reverse auctions be the presumptive method of purchase of generic pharmaceuticals and standardized pharmaceutical supplies.

Sincerely yours,

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